



STATE OF CONNECTICUT

DEPARTMENT OF MOTOR VEHICLES

60 STATE STREET WETHERSFIELD, CONNECTICUT 06161
<http://dmvct.org>



SUBSTANCE ABUSE TREATMENT PROGRAM WAIVER REQUEST FORM

Operator Name: (Please Print)	Date of Birth:	Date:	
Operator Address (Street)	(City)	(State)	(Zip Code)

Complete this waiver form and return it to the Department of Motor Vehicles, DMV, Driver Services Division, 60 State Street, Wethersfield, CT 06161.

As cited in Section 14-227f-6 of the Regulations of Connecticut State Agencies (RCSA) there are two separate components that must be completed for a petition for a waiver to be granted. The first is participation in a substantial substance abuse treatment program at a facility that meets Connecticut regulatory requirements. The second is to submit a letter from a licensed physician which states "based upon a personal examination; _____ (operator name) does not have a current addiction problem which affects their ability to operate a motor vehicle in a safe manner." This examination must be within 60 days of your restoration eligibility date.

If the program does not meet the requirements for a waiver request, you must contact one of the approved providers conducting the program for the Department of Motor Vehicles. This requirement must be completed prior to achieving restoration of your operator's license or privilege to operate in the State of Connecticut. A list of the approved providers can be found on the Department of Motor Vehicles website at ct.gov/dmv/SATP. Connecticut General Statutes and Regulations can also be found under the Publications link on the website.

The Alcohol Education Program does not meet the statutory requirements of a substantial substance abuse treatment program.

Inability to confirm certification that the program content meets the criteria of RCSA Sec. 14-227f-4 may result in denial of your petition.

<input type="checkbox"/> CERTIFICATION: This is to certify that _____ (facility name) meets the licensing criteria of RCSA Sec. 14-227f-7; and that the program in which the above person participated and completed was conducted by certified substance abuse counselors and the program content meets the criteria of RCSA Sec. 14-227f-4.		
Date Enrolled:	Date Completed:	Date:
I swear or affirm under penalty of false statement in accordance with Connecticut General Statutes §14-110 and §53a-157b, and subject to penalties for perjury for a deliberate false statement, that the program completion for the above named operator and any attachment hereto is true and correct.		
Name/Title of Authorized Person (Please Print):	Signature of Authorized Person (Please Print):	
Name and Address of Facility (Please print):	Telephone Number: ()	
<input type="checkbox"/> CERTIFICATION: This is to certify that the program in which the above person participated and completed at this facility fails to meet the criteria of the waiver requirements outlined in RCSA Sec. 14-227f-7.		
Name/Title of Authorized Person (Please Print):	Signature of Authorized Person (Please Print):	
Name and Address of Facility (Please print):	Telephone Number: ()	

9/2009